



6840 Seaview Road, Sechelt, BC V0N 3A4

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Optometry/Orthoptist Referral

Referral Information

Name: _____ DOB: _____ Grade: _____ Date of Referral: _____

Parent/Guardian: _____ Phone/Fax : _____

Physician: _____ Phone/Fax: _____

_____ has been identified as demonstrating the following academic difficulties possibly related to visual dysfunction:
(Child's Name)

- Reading
 Phys. Ed.
 Writing/Printing
 Math
 Spelling

Medical History

Visual History (previous visual assessments, training, surgeries, specialists, etc.)

OT Assessment Results

Bruininks-Oseretsky Test of Motor Proficiency _____

Gardner Test of Visual Perceptual Skills _____

Fine Motor Skills: _____

Adaptations currently in place:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> visual filters (colored transparency/paper) | <input type="checkbox"/> scribe or tape recorder | <input type="checkbox"/> pencil/pen grip | <input type="checkbox"/> modified 'containers' |
| <input type="checkbox"/> adapted paper
(raised or highlighted lines) | <input type="checkbox"/> visual keys
(L/window keys, 6" ruler
finger read) | <input type="checkbox"/> slantboard | <input type="checkbox"/> computer |
| | | <input type="checkbox"/> photocopied notes &/or assignments | |

Optometrist/Orthoptist Assessment Results

- | | | |
|---|--|---|
| <input type="checkbox"/> Saccades | <input type="checkbox"/> Convergence | <input type="checkbox"/> Visual Fields |
| <input type="checkbox"/> Pursuits | <input type="checkbox"/> Suppression | <input type="checkbox"/> Ocular Dominance |
| <input type="checkbox"/> Accommodative Skills | <input type="checkbox"/> Refractive Status | <input type="checkbox"/> Color Vision |

Optometrist/Orthoptist Recommendations

Return visit date: _____

Optometrist/Orthoptist: _____ Phone/Fax: _____